Clark County Children's Mental Health Initiative
Clark County, Washington
August 17–19, 2004

I. Background

A. *Details of the Site Visit*

The fourth and final system-of-care assessment of the Clark County Children's Mental Health Initiative (CMHI), also referred to as the Community of Care, took place on August 17–19, 2004. A team of two ORC Macro site visitors conducted a total of 25 interviews with representatives of the system of care, including the program coordinator, members of the governance council, representatives of public child-serving agencies, parent partners (family advocates), direct service providers, staff responsible for program evaluation and quality review, and caregivers whose children and families have been served by CMHI. Site visitors also reviewed randomly selected case records of children enrolled in various program components within the CMHI. The case records provided additional information regarding program development and adherence to system-of-care principles.

The following report is based on information obtained from the system participant interviews, case record reviews, and additional documentation provided by grant community staff. The report is organized into five sections:

- Background of the project
- A description of the system of care at the infrastructure level
- A description of the system of care at the service delivery level
- System of care strengths and challenges
- Sustainability efforts and lessons learned

B. *History and Background*

As a result of legislation passed in 1989, responsibility and accountability for mental health services in Washington State shifted from the State-level to county-based entities called Regional Support Networks (RSNs). The RSNs administer the State mental health funds to provide mental health services for individuals receiving Medicaid and others with low incomes. In southwest Washington, the Clark County RSN administers the mental health dollars and contracts with community mental health providers under the auspices of the Clark County Department of Community Services (DCS). In addition to mental health services, the Clark County DCS oversees drug and alcohol treatment and prevention, services for individuals with developmental disability, housing, community action programs, and youth and family services.

In April 1998, the Clark County DCS applied to the Federal Center for Mental Health Services (CMHS) for a grant to fund enhancements to its existing system of care, to further develop a comprehensive, integrated system of care for children with severe emotional disturbance. Emphasis was placed on infrastructure development and implementation of the concepts of

Individualized and Tailored Care (ITC) and the "wraparound" approach to service delivery. The grant application was approved for a period of 5 years, effective September 1998. Since that time, CMHS added another year to allow each grantee a 1-year planning and 5-year implementation period.

As a result of the efforts in Clark County, the Washington State legislature passed the *Engrossed Substitute House Bill 2574* in March 2002 to establish demonstration sites, that when implemented, will strategically support the children's system of care statewide.

Catchment Area and Target Population

The service area for the CMHI continues to be all of Clark County, Washington. Clark County is located in the southwestern part of the State of Washington, approximately 70 miles from the Pacific Ocean. The Columbia River forms the western and southern boundaries of the county. The land area of the county comprises 401,280 acres (627 square miles), approximately two-thirds of which lie in the foothills of the Cascade Range. The Clark County Department of Community Services is located in the urban part of the county considered part of the northeast quadrant of the Portland, Oregon metropolitan area.[1]

Clark County has gained attention as one of the faster growing areas on the national level. In 1980, its residents accounted for 4.7 percent of the State's population. As of July 2004, the total population in Clark County was 383,300.[2] This number represents above 6.0 percent of the statewide total. Growth in Clark County can be attributed to a number of factors including its relationship with, and proximity to, the Portland, Oregon metropolitan area, transportation facilities, and quality of life. Clark County is becoming more diversified with an increase in minority groups and ethnicity. Recent trends show an increase in all minority groups, particularly in the Asian and Pacific Islander, Black, and Hispanic Origin categories, as well as an influx of eastern Europeans. The White population for the county is still around 89 percent.

The CMHI targets children, including adolescents, and their families who have or who are at risk of developing a serious emotional disturbance, have a GAF or CGAS score of 50 or below, receive or need services in multiple domains, have a *DSM–IV* Axis I diagnosis, and who have a disability that has persisted or is expected to persist for more than 1 year in duration.

Evaluation data provided by Portland State University (PSU) covering the period from August 1, 2003–August 18, 2004, indicates that a total of 1561 youth currently are in the PSU national evaluation tracking system and qualify for the system of care according to the eligibility criteria above. A total of 796 children have been actually served by the CMHI system of care. Of the children served, the average age was 11 years, 9 months, 62 percent were male; the family median income range was $15,000–$20,000; 84.3 percent were White and 6.7 percent were African-American. Approximately 6.9 percent of the children and youth served were Hispanic and 4.4 percent were American Indian.

[1] Clark County Department of Assessment and GIS. 2003 Population and Economic Handbook.
[2] Washington State, Office of Financial Management.

Funding

For the current fiscal year (September 1, 2003–August 31, 2004), funding for Clark County's CMHI flows from several Federal, State, and local sources. These include:

Medicaid	$2,193,800
CMHS	$1,435,757
Clark County Juvenile Department	$ 875,000
Child Welfare Services	$ 93,949

Funds that are pooled come from the Juvenile Department, Child Welfare, and Medicaid (the RSN) as outlined above. A total of $200,000 is available through flexible funding budgets. Professionals and parent partners can submit flexible fund requests to a committee consisting of at least three members for approval.

Managed Care

Since 1995 Washington State has operated under a 1915(b)(1) Medicaid waiver to enroll Medicaid recipients in Prepaid Health Insurance Plans (PHIPs), replacing fee-for-service with a managed care system. Mental health services for Medicaid recipients are carved out in this waiver. In Clark County, consumer benefits are arranged through the Clark County RSN, which entered into a full risk, inpatient and outpatient mental health services contract with the State Department of Social & Health Services/Mental Health Division. The County also is responsible for providing or arranging mental health care for residents who are not covered by Medicaid, but who otherwise meet the eligibility criteria of the CMHI. The mission of the Clark County RSN is to promote mental health and ensure that residents of the Clark County region, who experience mental illness during their lifetime, receive treatment and services so that they can recover, achieve their personal goals, live, work, and participate in their community. The Clark County RSN now is in its eleventh year of operation as a PHIP.

In 2004, the Federal Centers for Medicare and Medicaid (CMS) changed the terms and conditions of the State's 1915(b) waiver. CMS required the State to establish a Community Reinvestment Fund for savings generated by waiver programs. Funds can be used by the RSNs for 1915(b)(3) services to support the development of community-based services for the prevention, early intervention and treatment of mental illness for Medicaid beneficiaries only. The Federal share of any funds from this account not used within 1 year of being placed in the fund or upon contract expiration or termination must be returned to CMS.

With respect to the CMHI, the Clark County RSN continues to see its role as "a quality overseer"—one of assessing the affects of managed care in relation to the quality of care delivered to children and their families. Providers are incentivized for improvements in family satisfaction and demonstration of the system-of-care principles.

II. Description of the System of Care at the Infrastructure Level

A. Governance

Since early 2002, the Community of Care Advisory Council (COCAC) has remained the single oversight entity for the CMHI. Its mission is to build and sustain an effective system of care in Clark County within four distinct domains: resources, structure, process, and community. The focus of the COCAC in the past year has been sustainability efforts including the development of a Memorandum of Understanding (MOU) across child-serving agency participants to continue the interagency collaboration carried out by this group.

At the time of this assessment, the COCAC consisted of 12 members with broad-based representation from all segments of the mental health service delivery continuum for children with severe emotional disturbance and their families. There continues to be five appointed positions of senior executives from public child-serving agencies such as the State Division of Child and Family Services (DCFS), Clark County Juvenile Justice, the Department of Community Services, a representative from the education system, and a County Commissioner. Community representatives include staff from the Vancouver School District, Catholic Community Services, and the Young Women's Christian Association (YWCA). There continues to be community and family member positions including a youth representative on the COCAC.

The Family Action Committee (FAC) still is in operation as a standing committee of the COCAC. The FAC was created to capture greater family voice for parents of children with serious emotional disturbance. The FAC is responsible for encouraging community participation and input to strengthen the system of care, to define the common barriers experienced by families, and to explore ways to improve services. In the past year, the FAC has spent time researching the feasibility of moving to a Commission structure located in different geographic regions of the county, with a family involvement specialist serving as the coordinator. A subcommittee of the FAC is the Community Partners Committee. It expands efforts of the FAC to assist children and their families to identify and access needed community-based resources. (See Case Review Section III-D for more information on this committee).

While the Resource Management Committee is no longer functioning, a Sustainability Committee was created to take on a more focused role on generating recommendations for sustainability and for leveraging system collaboration and funding.

The COCAC meets monthly from 11:30am–1:30pm on the third Monday of the month at the new Public Service Center. The FAC meets on a monthly basis also. The COCAC continues to hold open forums for the public on a quarterly basis.

B. Management and Operations

The Clark County Department of Community Services continues to have responsibility for the day-to-day administration of the CMHI grant. This responsibility includes staff support to the COCAC, oversight of grant-funded staff, staff at the Youth House, and mental health contractors, and management of the Children's Flexible Trust Fund. The Children's Flexible

Trust Fund is a discretionary fund to be used for individualized needs of CMHI children and their families.

Staffing Structure

The staffing structure for grant-funded positions for the CMHI has remained constant over the past few years. It includes staff who are part of the operations of the grant, as well as staff who are affiliated with CMHI through its various partnership projects and key contracted service providers. The three relevant groups are Clark County DCS, the Juvenile Justice Center, and Catholic Community Services. Each entity's staffing role is briefly described below.

Clark County RSN/DCS
The grant is managed and operated through the following individuals, some of whom are staff within DCS and the RSN and others who are contracted. The number adjacent to the positions reflects the number of persons with this title and not the relative FTE equivalent.

director (1)
deputy director (1)
youth program manager CMHI (1)
family support specialist (1)
family evaluator (1)
family resource specialist (1)
family resource liaisons (2)
family information specialists (3)
youth project coordinator (1)
administrative assistant (1)
financial analysts (2)
management analysts (2)
graduate research assistant (1)
contract manager (1)
information system manager (1)
data clerk (1)
Community Empowerment Project (2)
office support staff (1)

Connections Project Connections is a blended funding partnership among the Juvenile Court, CMHI, and the County RSN. The combined dollars fund four probation associates, four care coordinators, four probation counselors, and four family specialists. Teams comprised of representatives from each of these four different staff positions work with each youth and his or her family.

Catholic Community Services Clark County has contracted with Catholic Community Services (CCS), a not-for-profit service organization, to provide both crisis stabilization services and intensive wraparound services to children served by the grant program. The grant assists in funding the director, four administrative staff, five leadership staff, and 44 family preservation staff.

Training

Over the past year, the CMHI has offered training on family-focused care, cultural competence, individualized care, community participation, and youth transition. Training sessions have been available for grant-funded staff, families and child-serving agencies. Programs on family-focused care programs and cultural competence in particular, have had the greatest representation across mental health, child welfare, juvenile justice and the schools. Parent partners continue monthly meetings across the child-serving agencies for training on family-focused values.

C. *Service Array*

Since its inception, the Clark County CMHI has continued to respond to the requests of the community to expand the service array as needs arise. As a result, all grant-required services[3] are present in the service array. Other services or service enhancements have been added over the life of the program to include the parent partner program, mentoring and tutoring, transportation, drug and alcohol counseling, skills-building activities, and youth advocacy.

Children and their families continue to have access to the four mental health service providers in Clark County: Columbia River Mental Health (CRMH), the Children's Home Society, the Children's Center and Family Solutions. Service provider capacity was expanded within each of these agencies in the past year. As the crisis stabilization provider, CCS also continues its role in providing intensive wraparound services that are modeled after system-of-care values. Child and adolescent mobile crisis services are available and provided through CRMH.

Previous concerns expressed about the adequacy of respite care were addressed in January 2004, through the addition of a new provider contract with Innovative Services Northwest, formerly known as the Vancouver Children's Therapy Center. This organization is licensed as a child placement agency for special needs day care and services. It also screens children from birth to 3 years of age for developmental disabilities.

Family Resource Centers (FRC) continue to operate in Clark County. Staffed by both professionals and family members, these community-based resources offer education, social opportunities and access to community-based supports for families. Services offered may include childcare, health service, early childhood education, parent education, recreational programs, and workforce development. There currently are seven FRCs operating in Clark County.

Support services and advocacy for youth remain a consistent focus in Clark County through the efforts of the Clark County Youth Commission and the Youth House. The Youth House in particular supports CMHI by providing a physical space for youth and youth-driven organizations, for the purpose of supporting youth empowerment and youth and adult partnerships. In response to an increase in youth suicide, and suicide attempts and threats, the county created a Youth Suicide Prevention Task Force. The prevention plan developed by this group focused on increasing community awareness about suicide, enhancing school-based prevention programs, training on suicide prevention, and improving access to mental health services including an enhanced 24-hour response to crises.

The DCS conducted focus groups with teens, school staff, and community members to address the issue of suicide. Based upon the feedback obtained, DCS created Teen Talk, an interactive telephone line and website intended to serve as an informal support system for young people or for adults who have questions regarding a teen in their lives. In operation for over a year now,

[3]Services required in the grant's guidance for applicants include diagnosis and evaluation; case management; outpatient individual, group, and family counseling; medication management; professional consultation; 24-hour emergency; intensive home-based; intensive day treatment; respite; therapeutic foster care; and transition-to-adult.

Teen Talk is run by a network of teen volunteers ages 15–18, all of whom have completed 32 hours of training. Teen Talk can be accessed weekdays from 4:00pm–9:00pm.

Another service component that the CMHI has placed a great deal of emphasis on in the past year has been the youth-in-transition efforts. A Federal Partnerships for Youth in Transition (PYT) grant was awarded to DCS to develop models for supporting youth as they transition into adulthood. This includes addressing transitions such as completion of high school, vocational education, employment, independent living, social adjustment and cultural competency, for example. All staff agree that this grant closely aligns with the efforts started by CMHI. For example, the PYT analysis efforts identified various inadequacies in transitioning youth to the adult mental health system at the age of 18. One important finding was that the adult mental health system is not able to provide the more developmentally appropriate services that children with severe emotional disturbance need. So in July 2004, all provider contracts were amended to allow youth to stay in the children's mental health system, ensuring that provider reimbursement would continue.

D. Quality Monitoring

Responsibilities for the evaluation and quality monitoring activities of the CMHI have not changed in the past year. The two entities involved in program evaluation and quality monitoring activities continue to be the Regional Research Institute for Human Services at Portland State University (PSU) and the Clark County RSN Quality Management Department, respectively.

PSU has served as the external evaluator of the grant for the past 6 years. In this capacity, PSU evaluation staff have collected data from agencies and providers, conducted focus groups, and administered interviews with caregivers and children. Additional evaluation activities include, social network (interagency) analysis, assessment of juvenile justice recidivism rates, youth in transition barrier assessment, community involvement, drug use, and focused evaluations of each of the CHMI wraparound projects. PSU also continues to contract with the State for services relating to the CMHS national evaluation.

PSU gathers and analyzes data to assess child and family functioning outcomes, caregiver strain, family and youth satisfaction, and organizational and system-level assessment of wraparound. PSU now has 36 months of national evaluation outcome data on the CMHI and these data have been used to improve service delivery and as a barometer to inform program administrators of program effectiveness. During 2004, PSU sent out a questionnaire to assess the CMHI community's perception of whether the grant program has in fact reformed the children's mental health system. This information will be compared to a quasi "pre-test" that was circulated prior to the grant's implementation that assessed the community's expectations of what the grant was to accomplish.

Findings from PSU efforts are presented quarterly to the COCAC, to system stakeholders via a monthly *Children's System of Care Data Report* newsletter, and at national meetings on the children's system of care program. To date, PSU has been presenting evaluation data to over 300 stakeholders.

The Quality Management Department within the RSN has accountability for meeting quality review requirements of Washington State code. This department oversees the RSN's Quality Assessment and Improvement Committee which consists of RSN management staff, PSU evaluators, consumers, providers, and child-serving agencies. Relevant to the grant, this committee reviews processes and data related to the quality of care and services delivered to children, including PSU outcome data for the CMHI. Within the past year, other committee efforts include testing of a wraparound fidelity instrument for the Connections project, conducting provider record reviews to assess wraparound compliance, and the development of policies and procedures on evidenced-based mental health practice.

III. Description of the System of Care at the Service Delivery Level

A. Entry into the Service System

The process of entry into the CMHI system of care has remained constant over the past 12 months. Children still are screened and assigned an intensity level at the time of referral and intake. This intensity-based triage process is dictated by whether the child is in crisis or not. Upon this determination, the child then is placed into a wraparound project that best meets the child and families situation.

Assignment of Intensity Levels

There are essentially three levels of mental health care services within Clark County's CMHI. These levels are universal, targeted, and intensive.

Universal mental health services are brief to moderate in duration and have limited involvement with other child-serving agencies. The average duration of system involvement is approximately 3 months, with a minimum of 6–12 visits for assessment, counseling, therapy, or medication management. Families access universal services directly by means of self-referral or referral from another child-serving agency.

Targeted mental health services extend beyond basic clinic-based therapeutic intervention. Children and families in this category need more intensive services with greater flexibility in the time and location of services provided. Targeted services tend to be community-based and family-focused.

Intensive mental health services are designed for children and their families who have experienced a recent inpatient psychiatric treatment and who require high intensity services and lengthy service duration. These children have the greatest risk of out-of-community placement, have severe behavioral disturbance with moderate to severe functional impairment, and typically are involved with one or more child-serving agencies such as juvenile justice, child welfare, substance abuse, and the schools. Services needed include wraparound and crisis respite.

Universal services are provided by the three historic mental health service providers in Clark County: Columbia River Mental Health, Children's Center, and the Children's Home Society.

Targeted services are provided by the same three providers, as well as by Family Solutions. The intensive services are provided solely by Catholic Community Services.

Wraparound Projects

The approach to service planning and the wraparound team involved are dictated by which child-serving system referred the child and family and the service level of intensity needed.

There are currently two strengths-based wraparound projects associated with the CMHI, as well as the intensive wraparound services provided by CCS. One project is within the juvenile justice system and is known as "Connections". The other is called the School Proviso Projects within the Clark County school system.[4] Each of these is briefly described below:

Connections Project. Connections, a blended funding partnership between the Juvenile Court and CMHI, is a strengths-based program for probationary youth with behavioral health issues. Through application of the system-of-care principles, it is designed to deter youth from continued criminal activity once court-ordered supervision expires. Moderate and high-risk youth on community supervision are considered for the program. Probation counselors make the referral for youth who have a diagnosed behavioral health disorder, score of 1 or greater on the Risk Assessment Section 8 Mental Health, and who are residents of Clark County.

School-Based Mental Health Programs. There currently are five school-based mental health projects in operation. These projects have blended funds between mental health and the school system to support the community-based, individualized wraparound approach to service delivery. Each team has a peer parent supporter (parent advocate) and either a family resource specialist (care coordinator) or child intervention specialist.

Referral

Children are referred to the CMHI from a variety of different child-serving agencies including the school system, juvenile justice, mental health, child welfare, foster care, the developmental disabilities administration, the School for the Deaf, the School for the Blind, and other private providers. Essentially anyone can make a referral into the system of care, including families and other community-based individuals or groups.

The mental health intake screening determines whether the child needs targeted or intensive mental health services and the child and family is referred to CRMH or CCS for further evaluation. For the child in acute crisis, there is a 24-hour, 7-days-per-week Clark County Crisis Line with coverage by mental health professionals. When the family contacts this number, a therapist immediately speaks with the family. If the child is a potential harm to self or others, the family is promptly referred to the Crisis Assessment Team (CAT). The CAT then takes one of the following four actions: contacts the family by telephone, makes a home visit, meets the family at a location of their choice, or meets the child and family in the emergency room, if that

[4] In the 2003 assessment, there was a third project called the Title IV–E child welfare waiver demonstration project. This program ended in 2003.

is where the child is located at the time. Upon evaluation, the child is referred by CAT for targeted or intensive services.

The process from referral to first contact may be less than 24 hours sometimes within 20 minutes, in instances where the family needs crisis stabilization. Respondents noted that CCS makes a contact for intensive services within 1–3 days. Targeted services take no more than 1 week to receive. The completion of paperwork and a detailed intake does not occur until the crisis has stabilized and the first child and family team meeting has been held, usually within 1–2 weeks.

In addition to the standard eligibility requirements for children and families to receive services under the CMHI grant program, eligibility for services varies somewhat according to the provider providing the services. For example, Connections only serves children who are currently on probation with juvenile justice and CCS only serves children enrolled in Medicaid.

Outreach

CMHI has informed the community about the program through a variety of outreach efforts. For example, there are quarterly public meetings where outcomes data are presented and systems reform progress discussed. A Connections newsletter is circulated to families and providers, DCS has a mailing list for keeping stakeholders informed, and there is a CMHI domain on the Clark County DCS website. CMHI has seen a generalized increase in calls and awareness in the program; however, it is unclear if this is a result of their outreach efforts.

B. Service Planning

The primary venue for the service planning process continues to be the Child and Family Team meeting, at which children and families participate with other team members to create an individualized and tailored plan of care known as a "Family Support Plan" or "Individualized Service Plan." Accountability for service planning rests with a care coordinator, case manager, or family resource specialist, depending upon the wraparound project assigned. The "care coordination" role is to assure that planning, coordination, and implementation of the system-of-care approach follows accepted procedures.

Another key team member in both service planning and provision is the peer parent supporter, or "parent partner." The role of the parent partner is to ensure that there is an advocate for the family who can help them navigate the mental health care system. The parent partner is an individual who either has had or currently has a child with severe emotional disturbance receiving mental health services. Each family is assigned a parent partner as well as a care coordinator.

Wraparound team meetings initially are held weekly, then become monthly once the service plan is developed. Meeting locations vary depending upon the program providing care coordination. Service planning teams always include the family, care coordinator, parent partner, therapist, and the relevant agency representative. The child or youth also participates whenever possible and appropriate.

The wraparound service planning process begins with convening the child and family team. The purpose of the planning meeting is to help the family decide who should be added as members of the team, to conduct a "strengths chat" with the child and family (and in some cases, other team members), and to develop the individualized and tailored care plan. The development of the care plan is a central component of the wraparound service planning process. Serving as the team facilitator, the care coordinator works with the child and family to elicit needs and strengths across a series of nine domains, which include education, recreation, finance, safety, and cultural beliefs.

The median caseload for care coordinators is 26. Care coordinators can have caseloads as low as 16, and as high as 35. Respondents reported that care coordinators have been able to provide coordination of services despite the size of their caseloads.

C. Service Provision and Monitoring

The CMHI continues to report broad flexibility in times and locations for service delivery. Many services are available during evening and weekend hours, and RSN provider contracts require that 60 percent of services be provided outside of agency offices. Care coordinators from the different agencies, therapists, and other providers commonly meet children and families in homes, schools, juvenile court, and elsewhere in the community. Services are delivered to children and families based upon the results of the strengths chat and the individualized and tailored care plan. Care coordinators, parent partners, and other wraparound team members collaborate to find the services needed by individual children and families.

The processes and activities related to children and families' receipt of services is coordinated and monitored through the care coordinator and documented in the child's service record by the relevant service providers. Wraparound team meetings are held on a monthly basis to evaluate the effectiveness of services provided. In addition to these meetings, the care coordinator and parent partners conduct follow-up with families via telephone or in person to assess progress, do status checks, ensure services have been delivered, and assess family satisfaction. The frequency of these kinds of follow-up activities varies from weekly to daily, depending on the nature of the child and family situation.

D. Case Review

The entity with primary responsibility for providing case review services for the CMHI is the Community Partners Committee. The Community Partners Committee consists of representatives from public child-serving agencies including mental health, juvenile court and juvenile rehabilitation, Vancouver school district, developmental disabilities, Head Start, and child welfare. The key private mental health and respite providers for Clark County are participants also, as well as two family representatives. The purpose of this committee is to assist children and families in accessing community programs and services; identify resource gaps; develop services to assure least restrictive placement; and to ensure individualized, strengths-based service planning. This committee meets monthly during the day and once again during the evening, as needed.

Any agency, organization, provider, or family member may refer a situation to the Community Partners Committee. Most referrals still come from mental health agencies the Connections program or child welfare. Self-referrals also are common. As referrals come in, the committee chairperson screens them. The chairperson telephones the primary caregiver to further identify the child and family's needs and to determine whether review by the committee is necessary. Some families' needs are quickly met by resource suggestions from the chairperson during the telephone conversations. In some instances, if the child is already part of a wraparound team, the chairperson might contact the relevant care coordinator/case manager/family resource specialist, to determine what service options have been addressed at the child and family team meeting.

Families typically are participants in the process except when they are working during the day. After a Community Partners Committee meeting, the family receives a list of the service suggestions made, along with the names and telephone numbers of individuals who agreed to perform specific actions to help the child and family. Family satisfaction surveys are conducted immediately following the meeting and again a few months later. The committee hears reports of each child and family's progress at the next several monthly meetings.

IV. System of Care Strengths and Challenges

The following section outlines CMHI's strengths and challenges as they relate broadly to infrastructure and service delivery. The term *challenges* is used in a broad sense to identify areas in which the program has not yet made any efforts, or is still in the early stages of development, as well as areas that have been difficult to implement, or in which system-of-care principles have not been successfully achieved.

A. Family Focused

Strengths at the Infrastructure Level

- There is general agreement from respondents that family voice is respected and desired at the governance level. Although family participation on the COCAC continues to be sporadic, with three family members leaving since August 2003, family representatives who do participate are considered equal partners at the table. The Family Action Committee, a subcommittee of the COCOC, has served as the predominant forum for family input. With the dissolution of the Community Empowerment Project, respondents indicated the need for a more formalized community-based structure for family input outside of the DCS Parent Partner pool.

- Training programs on family-focused care continue to be held routinely. Parent partners have monthly update trainings, and cross-agency sessions for staff from mental health, juvenile justice, education and child welfare are held on a quarterly basis.

- The Parent Partner Program within DCS, now in its fifth year, continues to supply a pool of family members to provide support and information to families within the system of care. These individuals are part of the CMHI staffing structure, and function as

paraprofessionals to support families in the care of their children. Parent partners perform as leaders of support groups and help families to navigate the children's mental health system. They also are present in wraparound child and family team meetings. As one respondent noted, parent partners "serve as resources, not advocates, because (they) teach families to be their own advocates". Parent partners are located in the mental health agencies, at the Juvenile Justice Center, and in the schools. Respondents reported that the pool of parent partners provided through the RSN will be sustained.

- Family members continue to play a very active role in grant program operations. For example, family members participate in the recruitment and hiring of staff, participate in management and committee meetings, serve as staff in the parent partner pool, represent the family voice for DCS at State-level meetings on children's mental health, facilitate focus groups, present at national conferences, train providers and families on family-focused care, operate the Family Resource Centers, and assist in proposal writing to obtain additional funds.

- Information from outcomes data continues to be collected and analyzed as part of the national evaluation. Respondents pointed out that the findings from these data have yielded positive policy decisions at the RSN leadership level. For instance, after reviewing the data that showed caregiver strain was high, the Family Action Committee proposed to the COCAC the need for an increase in respite services. As a result, the RSN contracted with a new respite provider in 2004. At this juncture, there has been no follow-up to determine the effectiveness of this policy decision. Respondents stated that it would be extremely helpful if PSU could identify caregiver strain in relation to the specific child and family teams.

- Data on family experiences, (i.e., satisfaction), are being collected, analyzed, and used to improve service delivery. As an example, the Connections Program staff specifically asked the PSU evaluation team to look more closely at family satisfaction with Connections, as data revealed that caregiver strain was higher with families whose children are involved with the juvenile justice system. To address this, the parent partner role at the Juvenile Assessment Center was enhanced to provide greater caregiver contact and support. Systemwide care coordinator functions also are being evaluated based upon these findings.

- Family representatives continue to be an integral part of the quality monitoring and evaluation process. Family members are part of the PSU evaluation team and the RSN Quality Management Committee. At PSU, family members participate in the development of survey instruments, special studies, data collection and analysis, coordination of the interview process, serve as interviewers, and provide reports to stakeholder groups. In the past year, family members also have been presenters at the American Evaluation Association, Family Support America, as well as State and national system-of-care conferences.

Strengths at the Service Delivery Level

- Respondents continue to assert that entry into the CMHI is efficient and family-friendly. Respondents reported that even though there is a lot of paperwork to complete, staff assistance is provided. Families are contacted within 1 hour for crisis care and children needing other services are contacted within 24 hours of the referral to schedule the first child and family team meeting.

- The service planning process continues to emphasize family involvement throughout. Planning meetings generally are held only when family members can participate. Family members are treated with respect, are encouraged to take an active role in development of service plans and subsequent evaluations, and are invited to bring support persons to meetings.

- Family strengths continue to be assessed and services are identified and incorporated into service plans for each family. Examples of family strengths used to plan services include creating an opportunity for a mother and son who were very giving to work together as volunteers in a local volunteer effort; encouraging a father with a strong work ethic and work skills to work together with his son on a family project; a family who engaged in making crafts and jewelry was asked to teach a class on how to do it; and a family member who had good computer skills tutored another parent on how to use a computer.

- Respondents continue to agree that service providers include caregivers in the provision of services. Caregivers are kept informed of their child's progress and are encouraged to express opinions and offer suggestions. An example was given where the guardian of a child, the grandmother, recommended to the therapist that it would be better to focus on the child versus the child's mother.

- Service providers reported a few examples of the successful incorporation of family strengths into service provision, such as providing financial assistance so a family could participate together in a family Bible camp, or so a family could rent a movie. Case records reviewed also demonstrated use of family strengths in the provision of services.

- Respondents continue to agree that the Community Partners Committee is family-friendly, providing pre-meeting orientation, supporting parent partners at the meeting, and emphasizing that the family is "in charge" of a child's care.

Remaining Challenges

- For staff-level family representatives on the COCAC, meeting times and locations are considered to be convenient. Respondents noted, however, that for other families who might want to participate and who work, the daytime hours may be more of a problem.

- In the past, food and childcare were provided by the COCAC to facilitate family participation in meetings. Most respondents at this assessment reported, however, that these supports are not offered now. There continues to be agreement that in addition to

food and childcare, stipends for transportation and attendance would greatly improve involvement by families who are not paid staff members.

- Some respondents expressed concern that the Community Empowerment Project, which has served as a primary training resource for the development of the paraprofessional role, will not be sustained when the grant funding ends.

- Some respondents had a difficult time articulating how service providers involve the family in service planning and provision. They noted that there is greater emphasis on the child's needs than on the family's needs.

B. *Individualized Care*

Strengths at the Infrastructure Level

- The CMHI has ensured the provision of individualized care through a variety of mechanisms. These include flexible funding through the Children's Trust fund, staff training, a new respite contract, the wraparound approach, and the provider contract requirements that stipulate that services be provided through a process of Individualized and Tailored Care. The Connections Program was praised by respondents for doing the most to ensure an individualized approach to care. Large caseloads and the need for more peer-to-peer youth and family support were offered as reasons that not all child-serving agencies are doing as much as they could be in this area.

- CMHI continues to offer training on individualized care to grant-funded and mental health agency staff, and to families and youth. Programs include presentations by nationally recognized experts on wraparound, strengths discovery, transition for youth, the concepts of individualized and tailored care, increasing motivation and hope in others, and several programs on helping youth and families discover and use their unique strengths and core gifts.

- Valuing and supporting youth involvement in the planning and provision of services remains an ongoing focus of the CMHI. Respondents reported that the COCAC will continue to require two youth participants. The Youth House continues to enhance efforts to provide programs and forums for youth voice in the system of care. A major accomplishment according to respondents was the development of programs that address the high incidence of youth lost to suicide. In addition to the Suicide Prevention Program, the new Teen Talk program is viewed as another positive step in youth advocacy and support.

- Children are encouraged to participate in identifying their strengths and needs, choosing services and providers, and in identifying individuals to accompany them to meetings for support. Many children also have mentors.

- CMHI's service array includes all grant-required services, plus additional traditional and nontraditional supports for both youth and their families.

- Respondents familiar with the grant evaluation stated that national child outcome data collected over the past 36 months by PSU have received the greatest scrutiny and resulted in system improvements. In addition, the RSN's quality monitoring program has played a role not only in communicating these findings to stakeholders, but has participated in record reviews to assess the validity of the wraparound process.

- PSU continues to work closely with both the RSN and juvenile justice to closely monitor outcomes associated with Connections such as school performance and youth recidivism rates. The data show that Connections youth have higher graduation rates than the general wraparound population. As a result, service providers are encouraging more youth to participate in education programs in conjunction with therapy.

Strengths at the Service Delivery Level

- Individualized Family Support Plans, also called Individualized and Tailored Plans, continue to be developed for all children and families served by the CMHI grant program. Respondents agreed that children are engaged actively in the service planning process, to the degree that they are able and willing to be involved.

- Identifying children's strengths and incorporating them into the service plan is accomplished through the strengths chat initially conducted by the care coordinator and then continued during the wraparound team meetings. Respondents and case records provided numerous creative examples of how strengths were used to plan services, such as providing funds for an athletic child to attend a football camp as an incentive to keep up his grades; arranging a coaching position for a child who loves hockey, to instill responsibility and community involvement; and a therapist who rode a bike with a child during therapy to help the child to lose weight.

- Caregivers continue to acknowledge that services planned generally were a good match for the children's needs. However, instances were mentioned in which a child's need for a mentor to participate in activities with the child was not included in the plan.

- Children reportedly receive all services included in their plans over 90 percent of the time. Service plans may not be fully implemented in the following situations: the family moves out of the county; the family or the provider does not follow through; or the child decides against participating in the service.

- According to respondents and a review of sample case records, children's strengths continue to be used routinely to shape the provision of services. For example, an extroverted child was encouraged to make friends appropriately by placing him in a structured social environment, and a child was encouraged to establish a hobby using his writing and musical talents.

- Care monitoring continues to be the primary responsibility of care coordinators and reportedly is accomplished through frequent telephone and face-to-face contacts with families, telephone and written communications with involved agencies and providers,

and talking with participants at child and family team meetings. Monitoring efforts are routinely conducted on a weekly basis, but may be conducted as often as biweekly or daily, depending on the needs of the child and family.

Remaining Challenges

- In the past year, training programs on individualized care have been limited to the mental health community and families.

- Respondents pointed out that there still are limits in capacity for services that support youth and their families such as psychiatrists, mentoring, peer parent support, and respite. It is expected that respite services will improve however, with the new contract in place.

- The RSN has been conducting record reviews twice per year to assess the family's involvement in the wraparound process and to determine what specific services are being offered. Respondents reported that there has not been any aggregate or agency-specific data collected, nor have findings been used yet to improve systemwide performance.

- Involvement of children in the Community Partners Committee is limited to about 50 percent of reviews. Although respondents agreed that children would be welcome to participate in the Community Partners review meetings, not all children are willing, or functionally capable to participate. Sometimes parents do not want their child involved. When children are involved they are asked for their input on what they think are the problems being faced, and they are given a choice of services they could receive.

C. Culturally Competent

Strengths at the Infrastructure Level

- As a subcommittee of the RSN's Quality Management Committee, the Cultural Competence Committee has been charged with assisting CMHI in enhancing the level of cultural competence in Clark County. This includes setting the standards that address cultural competence requirements for providers. A set of clinical practice standards for cultural competency still is in place and being implemented as part of the RSN's provider contracts.

- Staff across all child-serving agencies, grant-funded staff, families and private providers have received training on the meaning of culture in service delivery.

- Respondents continue to report that even with a majority White population in Clark County, the CMHI has been successful in hiring parent partners to match the cultural diversity of the community served. The backgrounds of the families receiving services have included Russian, Hispanic, Laotian, Cambodian, African-American, and American Indian individuals.

- Almost all families served by the CMHI have English as their primary language. Even so, the CMHI has been able to consistently accommodate families who speak other languages. Provider contracts require that brochures be translated into languages such as English, Spanish, Russian, Vietnamese, Korean, and Cambodian. DCS has an Americans with Disabilities Act (ADA) compliance officer who examines specific language and communication needs. A network of interpreters has been identified and is available as needed, as well as the county having an AT&T language line. American Sign Language for persons who are hearing impaired also has been provided.

- In addition to the expertise offered by the Cultural Competence Committee, effective July 1, 2004, public mental health provider service contracts allow for financial incentives for providers to hire cultural consultants to assist them in addressing special needs populations. Special needs populations include racial and ethnic minorities, and individuals with developmental disabilities.

- Information related to the provision of culturally competent care has been collected and examined through the Cultural Competence Committee with the assistance of PSU. This committee conducted a community provider analysis to identify providers' needs with respect to ensuring culturally competent care. The review found that clinicians were not documenting cultural assessments, nor were they comfortable with documenting culture as part of the service plan. To address this, PSU is working with Oregon Health Sciences University (OHSU) to identify resources that can help staff create culturally relevant assessments and plans. In addition, it was noted that service providers were not meeting Washington Administrative Code (WAC) for ensuring consultation for special needs populations and implemented the consultant program noted above.

- Respondents reported that the quality monitoring process is culturally competent. The chair of the Cultural Competence Committee is a Russian youth. There also is an Asian representative on the committee. In the past year, family interviews have been conducted in Spanish, Russian, and American Sign Language. A measure assessing family perceptions of how well staff understand family culture was added to the satisfaction questionnaire in 2003.

Strengths at the Service Delivery Level

- The entry process reportedly has been conducted in Russian, Ukrainian, Spanish, and American Sign Language. There also are resources available to conduct intake in other languages as needed.

- The culture of the child and family continues to be assessed during the initial strengths chat, during wraparound team meetings, and during home visits. Examples of using information about culture to plan services include connecting an American Indian family to a traditional dancing group; assisting a minority child join the Minority Youth Leadership group to connect with this aspect of his life; and assisting an American Indian child and family locate sources in Native American spirituality and history, such as pow-wows and healing ceremonies.

- Whenever possible, children and families are linked to providers of similar cultural backgrounds. Other examples of ways that providers have used culture to help direct provision of services include not planning activities during cultural holidays, such as Asian New Year; encouraging parents to attend church with their child who once attended with his grandparents; and helping a child connect with people who could help her get involved with Irish dancing.

- The language preferences of the child and family can be accommodated during service planning and provision. A few bilingual providers are available who speak Russian, Spanish, and American Sign Language. In addition, interpreters are available as needed during the service planning and service delivery processes.

- Although the need has not yet arisen to accommodate a language other than English at a review meeting, the case review bodies are prepared to provide interpreter services as needed. A private agency in Portland provides interpreters who are familiar with both the language and the subject area of the discussion.

Remaining Challenges

- Respondents continue to have some difficulty describing how cultural organizations and community groups are used to help develop the service array, advise providers, or modify existing programs and services to address the cultural needs of the children and families served. OHSU was mentioned as having a role in cultural training. Currently, the child and family team meeting is the primary vehicle for cultural assessment, and the RSN offers assistance if the family requests help around a specific cultural issue.

- Although the Cultural Competence Committee has provided suggestions and training on the culture of poverty, there has been no specific outreach directed to specific cultural groups.

- Although the culture of the family is routinely assessed there is little evidence in a review of case files to suggest that culture is routinely incorporated into service planning.

- Efforts to collect information on the cultural diversity of case review group membership have not occurred at this time.

D. Interagency

Strengths at the Infrastructure Level

- In the past year, four child-serving agencies have actively participated in the COCAC. These agencies include mental health, juvenile justice, child welfare, and education. Several respondents commented on the less-than-routine participation by the schools in the more recent months, and of the importance of having schools represented at the table. Other suggestions for COCAC involvement included public health, the State child

welfare office, and a fiscal representative to provide insight and review of budgetary issues.

- With the grant coming to a close, there is agreement from members of the COCAC that interagency collaboration is critical for successful child and family outcomes. Though governing body participation has been voluntary over the past several years, five entities including Clark County Board of Commissioners, Department of Community Services, the Department of Child and Family Services, Juvenile Justice Services, and the Educational Services District 112, now have drafted a memoranda of understanding (MOU) to ensure that an influential structure will continue toward sustaining the system-of-care approach. At the time of the assessment, completion of this MOU was still in progress.

- Respondents reported numerous efforts to integrate staff across agencies. These include joint training on wraparound, and shared staff positions between mental health and the School Proviso projects, and mental health and Connections. Mental health staff also are outstationed at schools, juvenile justice, and child welfare. A new "liaison" position was created by the RSN to assist child welfare onsite (2.5 days per week) with greater understanding of direct service resource availability. The Partnership in Youth Transition (PYT) program also is involved with the Youth House by providing a care coordinator to work with a team of five transition specialists who support 60 youth.

- A new blended funding project has been created to include child welfare, mental health agencies, and the educational services district (ESD) 112.

- Two child-serving agencies, mental health and juvenile justice, are actively involved with PSU and the RSN in grant program evaluation activities. Particular emphasis has been placed on the outcomes related to the Connections Program. Juvenile justice staff collect and review data and work with the RSN to make needed system changes.

Strengths at the Service Delivery Level

- Three of the public child-serving agencies routinely refer clients to the CMHI. These are juvenile justice, child welfare and mental health. Because family resource specialists and care coordinators are co-located in some schools, most referrals typically come by way of these mental health staff on behalf of the school. Public health is not an active referral source at this time.

- The core child-serving agencies continue to be involved with a child and family (mental health, child welfare, and schools), and have routinely participated in service planning. However, respondents noted that child welfare and school personnel are not always involved consistently in the planning process; sometimes only participating when they think their goals and agenda will be met. School personnel will attend team meetings only if they are held at the school.

- All agencies are welcome to make referrals to Community Partners for case review. The sources of most of the referrals are mental health, juvenile justice, or child welfare. Occasional referrals also have come from Public Health, school counselors and EOC Head Start.

- There are representatives from mental health, child welfare, juvenile justice, the schools, developmental disabilities, substance abuse, and Head Start in the case review process.

Remaining Challenges

- Respondents varied in their knowledge about efforts to share administrative processes among the child-serving agencies. Some commented that no efforts were in place, while others spoke of activities such as jointly developing staff training materials, participating in recruiting and hiring, and holding joint staff meetings. In general, there is consensus that opportunities for improvement still exist in this area.

- There have been limited efforts to involve multiple child-serving agencies in the evaluation and quality monitoring process. While the Quality Management Committee receives reports on the system-of-care evaluation, its membership represents mental health primarily. In the past year, however, the PYT grant created a steering committee with representatives from child welfare, juvenile justice, the schools and mental health, to address transition issues. Respondents pointed out that the juvenile justice (Connections Program) is more likely to serve transition-age youth, and that data used will come from some of the system of care youth and families.

- Though there has been some work performed by PSU to evaluate the effect of interagency integration on system performance, the efforts have been part of the PYT Social Network Analysis project. Respondents reported that, to date, these data have not been used to make policy or service delivery changes.

- While the intake process typically occurs through the mental health system, respondents reported that two child-serving agencies are involved in the process. Juvenile justice has four qualified mental health professionals who conduct intake, and there are mental health staff that can conduct intake at the schools. As of May 1, 2004, the new case manager resource liaison is located, a few days per week, at child welfare and works with families to help them understand the intake process.

E. Collaborative/Coordinated

Strengths at the Infrastructure Level

- Respondents continue to express satisfaction with the level of communication provided by the CMHI. CMHI uses a variety of methods to update agency providers on grant program activities. These include opportunities for interagency training, quarterly newsletters, electronic mail correspondence, press releases, and the Clark County DCS

CMHI Web site. Agency staff participants on the COCAC continue to serve as conduits for the dissemination of information within their agencies.

- Respondents reported many examples for ways that services are coordinated across providers, agencies, and organizations. Coordination approaches include interagency staff meetings, wraparound team meetings, the Community Partners case review committee, cross-agency systems training, case manager meetings, and the COCAC. Respondents reported that these venues are very effective as measured by the ability of children to stay in the community for care. "Systems Glitch" meetings are ongoing also, and are held when families seem to be caught in the middle of decisions between or among agencies.

- CMHI demonstrates extensive efforts to assess how well services are coordinated. For example, transition-of-care studies concluded that families were not happy moving their children out of the children's mental health system at the time a child turns 18.

Strengths at the Service Delivery Level

- Outreach efforts to inform other agencies, providers, and organizations about the grant have continued. The director of CASA (Court Appointed Special Advocates) also is a COCAC participant.

- Most respondents continue to agree that the providers and organizations involved with a particular child and family frequently participate in the service planning process, although this is not always true for every child and family served. Such participants have included private therapists, sports coaches, pastors, mentors, natural supports from the extended family and community, staff from Weight Watchers, baby sitters, and scout leaders. Staff from the Children's Home Society, and the Family Resource Center also participate.

- Wraparound is the primary vehicle for enhancing coordination and collaboration among agencies, organizations, and providers. In addition to the team meetings, care coordinators and other agency caseworkers frequently attend other service planning meetings such as Individual Education Plan (IEP) meetings, DCFS staff facilitator meetings, and parole officer meetings, foster care meetings, and meetings to discuss disciplinary issues.

- Efforts are made by care coordinators to coordinate service provision through wraparound and through regular contact with team members between meetings, by electronic mail and telephone, and providing meeting notes for those not in attendance at the wraparound meetings.

- The care coordinator is considered key to the success of service transitions. Respondents reported that cooperation between the existing and new providers also is essential, and that members of the wraparound team must be involved in the process also. The care coordinator typically follows up with the family and providers after a transition is made and reports back to the team. However, CCS encourages families to be independent and

establishes an official cut off date after which all communication with a family officially ends.

- As reported during previous site visits, all agencies involved with a child and family's care continue to routinely attend the Community Partners Committee review meetings, but no summary of the meeting is printed or disseminated to attendees because of confidentiality issues. However, a triplicate form is used during the meeting to identify tasks assigned and the individuals who agreed to follow up with those tasks. A copy of this form goes to the family, to the persons agreeing to perform the tasks, and to the committee chairperson.

Remaining Challenges

- Many respondents reported that service transitions could be better coordinated. Agency participation was noted as problematic, and it was reported that Juvenile Justice does not customarily follow up with clients who transition out of the program. Instead a cut off date is established, and families are encouraged to use new sources of support that were developed.

- Although any private provider or non-agency organization involved in a child's care could refer a case for review, neither case review body has received such a request.

F. Accessible

Strengths at the Infrastructure Level

- For this assessment period there is general agreement that there are no or minimal financial barriers to care. Many children are on Medical Assistance. Children and families who are uninsured or with private insurance that may not cover needed services, care is provided through the use of flexible funds or grant dollars. In addition, provider agencies are required to have sliding-scale fees for children and their families.

- Efforts to expand the service array have been successful. Respondents described a broad and rich service array. Examples of capacity expansions reported in the past year include a new respite provider contract with special needs day care and screening for developmental disabilities in children ages birth to 3 years; modifications to provider contracts to allow children to remain in the children's mental health system until the age of 21; a case manager position created to serve as a liaison between DCS and child welfare to ensure that DCS staff are aware of, and take advantage of, available county services; and additional drug and alcohol treatment beds for males that allow access to the wraparound and home-based service focus. The three mental health service provider agencies also have added full time equivalent positions to their staff.

- Contracts with the RSN still require that service providers demonstrate that 60 percent of mental health services have been provided in the community versus the clinic setting, and that nontraditional services such as art therapy, recreational programs, camps, mentoring

and parent partnering should be reimbursed. Performance-based contracting with mental health providers also continues.

- The RSN is responsible for monitoring service accessibility according to WAC access requirements. Respondents were unaware of other efforts in place to use accessibility data to improve service delivery.

Strengths at the Service Delivery Level

- Several efforts to reach out to the target community were reported by respondents, including a newsletter circulated by Connections; a mailing list; and a Web site. The Community Empowerment Project also contributed significantly to outreach during the past year by providing training to families on mental health. Families also learn about CMHI through the Family Actions Committee, where families can come to voice their concerns and give feedback.

- Respondents reported that, for the most part, the process to enter the service system is uncomplicated. It was reported that the amount of paperwork to complete can be overwhelming. The time between referral and first service contact ranges between "immediate" to one and a half weeks; however, it appears that most services begin within 24 hours.

- The majority of service planning meetings are reportedly held at the schools. They may also be held at the office, the family's home, or elsewhere in the community if that is more convenient for the family. Most meetings are scheduled in the afternoon after school, but can be held in the evening, or in the early morning, if necessary to meet working family needs. During the summer, daytime meetings are common.

- Respondents continue to report that most services in the service array have sufficient capacity. Most services reportedly are accessible in a timely manner within 2 weeks; however, some services have longer waits: neurological and/or neuro-psychological assessment, medication management, and respite care.

- Service providers work flexible hours including evenings. Children and their families receive services 24 hours per day; 7 days per week, and most case managers do not have set schedules. Service providers can be reached by telephone or pager in an emergency, and in crisis situations, staff can be reached by contacting the Clark County crisis line. Some providers are available on the weekends, and one children's center has Saturday hours. Columbia River Mental Health has outstationed staff at the Family Resource Centers. Service providers meet with families at any suitable location that the family prefers, including schools, homes, juvenile court, other agencies, or elsewhere in the community.

- Transportation assistance continues to be made available to families in a variety of forms, including gas vouchers, bus passes, assistance with car repairs, taxi fare, and direct rides by staff. Public transportation services are limited to the city of Vancouver and do not

serve other parts of the county, so transportation assistance is important for many families.

- Respondents continue to agree that over the past year, there rarely have been any financial barriers to accessing needed services. Even for families with private insurance, CMHI will help with co-payments if needed, especially for neurological assessments, counseling or alcohol and drug treatment.

Remaining Challenges

- As of December 31, 2004, respondents pointed out that cost will be a barrier for the uninsured and privately insured families who are not eligible or not enrolled in Medicaid. Most insurance will not cover wraparound. In some cases, services previously rendered will be viewed as not being "medically necessary" unless the child is in crisis. Those children who have private insurance will continue to be served by Connections if they are not on Medicaid; however, as advocates and families both note, the child has to have committed a crime to be in Connections.

- Given these new financial considerations, families and providers express deep concern with how children and families not covered by Medicaid will be able to afford the expansive service array that is available to them. Also of greater concern to CMHI staff is that families believe that the "grant" is responsible for these financial cuts, which in fact are stemming from new limitations to the State's 1915(b)(1) waiver, occurring simultaneously to the end of grant funding.

- Many respondents noted a continued shortage of child psychologists leading to long waits for access. Crossing the river into Portland, Oregon reportedly is not an option due to different State and County regulations.

- A challenge to service planning and service provision continues to be getting wraparound initiated on evenings and weekends for the schools and child welfare in particular.

- The Community Partners Committee will accommodate evening meeting times if that is essential for a family's need, but meetings continue to be held at the DCS office downtown.

G. *Community Based and Least Restrictive*

Strengths at the Infrastructure Level

- Clark County continues to offer a rich and comprehensive array of traditional and nontraditional services within the community. Provider contracts specify that services be provided in the community.

- Agency providers, grant staff, and families all have received training on the use of least restrictive community-based care.

- When interviewees were asked what has been done to minimize the need for children and families to travel out of their home community for services, a consistent response was, "we just don't do it". One respondent stated excitedly that "one judge now doesn't send kids out of the community because of the wraparound team".

- There is general consensus across respondent groups that keeping children in the least restrictive placement within the community is the philosophy of the Clark County RSN and subsequently of the CMHI. Policy decisions are driven by how children can be best served in their homes and local areas. Other successful efforts include the wraparound approach, the use of intensive home-based services and natural supports, flexible funding, the Community Partners Committee, interagency coordination efforts, and frequent utilization-data analysis. All respondents reported that these efforts have been effective in keeping children in the community greater than 95 percent of the time.

- Respondents reported that because so few youth leave the community for out-of-home placement, little is done to study these trends. The RSN continually examines data, especially crisis and emergency room use. The Southwest Emergency staff are studying emergency room admissions and providing feedback to the RSN. PSU noted that it does look at where children are placed over time. To date, service improvements have not resulted from these analyses.

- As part of the national evaluation, PSU has conducted studies on where children live, i.e., the percent of children who live in a particular "restrictive" setting, at different points in time, such as foster care or group homes. PSU studies older and younger youth placement restrictiveness and housing needs, indicating that older youth are more at risk of homelessness. The PYT program now is looking at options for addressing the housing needs of youth based upon this information.

Strengths at the Service Delivery Level

- Children and families reportedly can receive all services in the community. In rare cases a child and family will have to cross the river to Portland for inpatient or residential care, a distance of only 5 to 10 miles.

- Respondents continue to agree that the Community Partners Committee is dedicated to exploring and locating community-based and least restrictive service options for all children and families whose situations are reviewed. Services such as crisis stabilization and intensive home-based services help to assure that children and families can receive services within their home communities.

- When children are placed in more restrictive settings, wraparound teams continue to meet to discuss their situations, note progress made, and discuss ways to help them successfully transition to less restrictive settings as soon as possible, such as developing safety plans and transition plans.

- Procedures are in place to bring all parties together to exhaust less restrictive options before more restrictive placements are made, as well as to transition out those children being served in overly restrictive settings.

Remaining Challenges

- Respondents noted that a big challenge moving forward will be to balance the wraparound process and promoting family voice, to the desire by DCS to not use residential placement. There are times when families feel that out-of-home placement is warranted, and individual to the child and family situation.

- Respondents reported that there is no extended inpatient stay in Clark County. Families must travel to Portland, Oregon or to Olympia or Seattle, Washington. Again, respondents reported that families express a continuing desire to have short-term inpatient hospital stays available as an option.

V. Sustainability and Lessons Learned

Sustainability

In its final year as a CMHS grantee, the Clark County Department of Community Services reports that it will be able to sustain almost all of the CMHI grant-related efforts that were intended to support the County's vision of building and sustaining a community of care for children and their families. In keeping with the goals of the grant as written in the original grant proposal, many believe that a true reform of the children's mental health system has occurred. There is evidence also that the philosophies of cultural change through collaborative partnerships, and the implementation of the principles of the system of care promoted in the CMHI, have been embraced at the State level to move the larger mental health care system in a more positive direction.

There are two significant challenges the CMHI community has identified moving forward. Changes to the State's Medicaid 1915(b) Waiver and the requirements to implement a Community Reinvestment Fund in Clark County effective January 2005, have raised concerns about how children and families who have no insurance or who are privately insured, will be able to access mental health services. There is general consensus throughout the child-serving agencies that this fund will limit the RSN's creative ability to use flexible funds for children and families who are not eligible for Medicaid, and who would otherwise not receive services.

Secondly there is not a formalized structure or forum for family voice outside of the Family Action Committee. The dissolution of the Community Empowerment Project, which provided training and technical assistance for families, has created a void in family-focused services. Though family voice continues as an integral part of service delivery, especially with wraparound, the jury is still out as to whether all agencies (outside of the DCS Parent Partner Program), will embrace this aspect of the system of care. To sustain the family voice, the Family Action Committee has recommended that the County create a Family Committee structure within

regions of the county. In addition, program administrators reported that the Mental Health Division plans to offer training to paraprofessionals free of charge and will certify all parent partners, fulfilling a training function provided by the Community Empowerment Project previously.

Major Achievements

There are several strong indicators that the Clark County CMHI will be sustained. These major achievements as reported by the grant program stakeholders are as follows:

- From an infrastructure perspective, the State Department of Health and Human Services (DHHS) to which the State-level Division of Mental Health reports, has applied for a statewide system-of-care grant.

- Respondents reported that the Clark County CMHI has transformed the operating culture across child-serving agencies. Philosophically and in practice the principles of the system-of-care have been infused across key stakeholders from the State level down to the service provider level. While there still are a few challenges with changing the practice of traditional mental health service provision such as after hours care and flexibility for hours worked, there are clearly defined expectations for system-of-care implementation. For example, provider contract language, memoranda of understanding across agencies, creation of an multi-agency, collaborative oversight structure in the Community of Care Advisory Council, which is still operational, provider outcome incentives, and blended funding projects have contributed to sustainability and system change.

- The Connections Program is seen as one of the greatest successes. Not only have all structural and service delivery components been sustained (and expanding), the national and PSU evaluation data have demonstrated positive outcomes for children and families with concomitant cost savings.

- There is evidence of blended funding efforts. Approximately 1.2 million dollars have been blended between mental health and juvenile justice for the Connections Program, two-thirds of which are juvenile justice dollars. Another blended funding effort is in development as an outgrowth of the Title IV-E demonstration project that ended last year. Referred to as "the Blended Funding Project" child welfare, DCS, and the educational services district (ESD) 112 will fund wraparound and expanded IEP services for children who meet the severe emotional disturbance criteria, who are in the child welfare system, and who also have an IEP in the school. Currently, child welfare spends approximately $6,000–$8,000 per month for each child who meets these criteria.

- A Parent Partner Program is continuing to provide support for families and to help strengthen family voice in the system. This program has supported over 235 families through the beginning of 2004.

- As another means of leveraging dollars to support youth programs and services, the Clark County RSN created a Youth Foundation, a Youth House, and started a Teen Talk Line that is run by volunteer youth.

- The Partnership for Youth in Transition (PYT) grant will build upon the CMHI to further enhance reform efforts.

- Integration of staff across child-serving agencies will continue. There are mental health staff co-located in schools, juvenile justice and child welfare.

- Evaluation and quality monitoring data are being used to make service improvements and influence policy decisions at the State and local levels.

Lessons Learned

For communities that desire systems change, the CHMI grant community voiced these key suggestions based upon lessons learned over the past 6 years:

- It is very important to invest the grant dollars toward infrastructure development early on, instead of using the funds to expand service capacity, despite what the service providers ask for.

- To develop true systems integration, all stakeholder agencies need to cooperate fully. Roles and responsibilities, especially for those who sit on committees, should be clearly defined.

- Feedback from youth and families needs to be in "real time" not through annual surveys only.

- Maintaining family involvement in the decisionmaking is critical and will occur only when the family voice is part of the infrastructure design.

CMHS National Evaluation
System-of-Care Assessment Scores

Clark County (Vancouver), WA
August 17–19, 2004
Assessment #4

	OVERALL AVERAGE	Infrastructure Domain					Service Delivery Domain				
		Governance	Management and Operations	Service Array	Quality Monitoring	INFRA-STRUCUTRE AVERAGE	Entry into Service System	Service Planning	Service Provision	Case Review Structure	SERVICE DELIVERY AVERAGE
Family Focused	**4.11**	4.47	3.56		4.20	**4.16**	5.00	4.40	3.43	4.25	**4.08**
Individualized	**3.85**		3.67	3.60	3.50	**3.59**		4.24	3.59	3.00	**3.96**
Culturally Competent	**3.55**		5.00	3.00	4.00	**3.86**	3.00	3.50	3.63		**3.45**
Interagency	**3.68**	4.07	3.18		2.67	**3.53**	3.00	3.88		4.80	**3.94**
Collaborative/ Coordinated	**3.80**		4.56		5.00	**4.60**	4.00	3.73	3.33	3.67	**3.55**
Accessible	**4.28**		3.67	4.23	3.00	**4.03**	4.46	3.83	4.58	2.67	**4.33**
Community Based	**4.42**			4.83	3.00	**4.57**			4.40	4.00	**4.33**
Least Restrictive	**4.20**		4.50		4.00	**4.43**			3.67		**3.67**